ARTIGO ORIGINAL

PATIENT-CENTERED CARE: A STUDY IN CLINICAL AND SURGICAL HOSPITALIZATION UNITS

Natalia Antiqueira Garcia[1], Laurelize Pereira Rocha[2]
Raissa Garcia Brum[3], Laís Farias Juliano[4]
Caroline Passos Arruda[5], Julia Severo dos Santos[6]

Highlights: (1). Patients' experiences of patient-centered care demonstrate satisfaction with care. (2). A safe environment and family support are essential for ensuring quality care. (3). Effective communication is a key determinant of quality patient care.

PRE-PROOF
(as accepted)
This is a preliminary, unedited version of a manuscript that has been accepted for publication in Revista Contexto & Saúde. As a service to our readers, we are making this initial version of the manuscript available, as accepted. The article will still undergo review, formatting, and approval by the authors before being published in its final form.

http://dx.doi.org/10.21527/2176-7114.2025.50.16878

How to cite:
Garcia NA, Rocha LP, Brum RG, Juliano LF, Arruda CP, dos Santos JS. Patient-centered care: A study in clinical and surgical hospitalization units. Rev. Contexto & Saúde. 2025;25(50):e16878

[1] Universidade Federal do Rio Grande – FURG. Rio Grande/RS, Brazil. https://orcid.org/0000-0002-9942-2590
[2] Universidade Federal do Rio Grande – FURG. Rio Grande/RS, Brazil. https://orcid.org/0000-0001-9334-6550
[3] Universidade Federal do Rio Grande – FURG. Rio Grande/RS, Brazil. https://orcid.org/0000-0002-0120-801X
[4] Universidade Federal do Rio Grande – FURG. Rio Grande/RS, Brazil. https://orcid.org/0000-0002-0593-0181
[5] Universidade Federal do Rio Grande – FURG. Rio Grande/RS, Brazil. https://orcid.org/0000-0001-8475-1474
[6] Universidade Federal do Rio Grande – FURG. Rio Grande/RS, Brazil. https://orcid.org/0000-0003-0138-6737

PATIENT-CENTERED CARE: A STUDY IN A CLINICAL AND SURGICAL HOSPITALIZATION UNIT

ABSTRACT

Objective: To understand patient-centered care from the perspective of adult inpatients during hospitalization. **Method**: This qualitative, exploratory, and descriptive study was conducted with 31 patients admitted to the medical and surgical units. Data were collected through recorded interviews, which were transcribed, validated, and processed using Iramuteq software. Categories were constructed based on the Institute of Medicine's guiding principles for patient-centered care, and content analysis was applied. The study complied with ethical principles for research involving human subjects and was approved by the Institutional Review Board of the Federal University of Rio Grande do Sul (CAAE No. 73679623.4.0000.5324). **Results**: Four categories emerged: respecting patient preferences; information, education, and integration of care; physical comfort and emotional support; and access to care. Including patients and family members in the care process is essential to ensure greater safety, understanding, and support. **Conclusions**: The study offered insights into patient-centered care from the perspective of patients and families, revealing both strengths and obstacles to its consolidation. It highlights the importance of patients' role as active participants in creating a safe environment and improving clinical conditions.

Keywords: Patient-Centered Care. Patient Participation. Quality of Healthcare.

INTRODUCTION

The World Health Organization (WHO) global strategy emphasizes the need to transform the care delivery model by promoting person-centered approaches. These approaches incorporate the perspectives of individuals, families, and communities, recognizing them as active participants in the co-development of health services, in addition to being users of such services. This approach seeks to address expectations, preferences, and needs in a humane and holistic manner, prioritizing comprehensive and respectful care[1].

The term "patient-centered care" was introduced in 2001 by the Institute of Medicine (IOM) of the United States to describe one of the attributes of quality in healthcare. It was defined as "care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions"[2].

Meanwhile, this approach of care prioritizes respect for and responsiveness to individual preferences, needs, and values, while also considering individual physical, psychological, and social aspects. The approach aims to be positive, allowing patients' preferences to guide clinical decisions, strengthening the bond between patients and healthcare professionals, and fostering greater shared responsibility for care. Furthermore, respecting individual autonomy and choices is fundamental, with clinical, legal, and psychological relevance[3,4].

Health and illness directly impact quality of life, making health communication a critical component of care. The intimate and sometimes overwhelming nature of health-related issues can further hinder this communication. In this context, patient-centered communication is essential for achieving optimal health outcomes, aligning with the historical values of nursing, which advocate individualized care that is sensitive to patient concerns. Considering the predominance of in-person and technology-mediated interactions in healthcare settings, it is crucial to explore and clarify who is involved, what is being communicated, where, when, why, and how these interactions occur, ensuring that individuals, families, and communities receive appropriate health care and services[5].

Patient-centered care involves the joint development of a plan based on priorities negotiated between the healthcare professional and the patient. Making care integration more respectful requires recognizing individual vulnerabilities, understanding the explanatory model of the condition, and establishing a shared framework of care among all stakeholders[6].

Therefore, it is important to investigate whether the healthcare team includes the patient as a protagonist in their care during hospitalization, recognizing that participation is essential for positive outcomes. This provides the rationale for the present study, which aims to explore patient-centered care from the perspectives of adult inpatients during hospitalization.

METHOD

Study design

This is a qualitative, descriptive, and exploratory study. The three domains comprising the 32 items that guide the development of qualitative research were applied, based on the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines[7].

The study was conducted at a university hospital in southern Brazil, administered by the Brazilian Hospital Services Company (*Empresa Brasileira de Serviços Hospitalares - EBSERH*). The institution provides care exclusively through the Unified Health System (SUS) and serves as a reference center for six municipalities, offering medium- and high-complexity care services[8].

Study setting

The university hospital has 212 beds linked to the Unified Health System (SUS), distributed across eleven units. The study was conducted in two specific units: the Medical Unit (MU), which is responsible for adult patients requiring clinical care and has 49 beds, including six private isolation units and four cohort isolation units with two beds each; and the Surgical Unit (SU), which has 32 beds dedicated to the care of adult patients in the preoperative and postoperative periods of general surgeries.

Both units receive large numbers of hospital admissions, allow patients to be accompanied by their families, provide care for adult patients regardless of the clinical or surgical specialty required, and serve those with specific needs related to their conditions and pathologies. Based on these criteria, the units were selected for the study.

Population, inclusion criteria, and sampling

Study participants were patients admitted to the MU and SU during the data collection period, as well as their family members. As postoperative patients were approached during hospitalization, family members who were present were also interviewed to address the principles of patient-centered care and to reinforce the information provided by patients. The inclusion criteria were: patients over 18 years of age and family members involved in patient care during hospitalization (in cases of cognitive or speech impairment).

Exclusion criteria were: patients admitted to the unit for less than 24 hours, those discharged from the hospital, those transferred to the Intensive Care Unit (ICU) or another facility at the time of data collection, and companions not related to the patient. Consequently, one participant was excluded for having been hospitalized for less than 24 hours.

Non-probability convenience sampling was used to select participants, based on the inclusion and exclusion criteria and their availability. At the end of the data collection period, the final sample consisted of 31 patients. One participant was excluded for not meeting the minimum hospital stay criterion of 24 hours.

Study period and data collection

Data collection took place from December 2023 to March 2024, beginning after approval had been obtained from the Institutional Review Board and the Management and Research Center of the university hospital. It was conducted through individual interviews, guided by a semi-structured script (Appendix A) that included participant characterization data and open-ended questions related to the study objective, such as the frequency of visits and care provided by professionals, receipt of information about health status, medications, and procedures, as well as patients' perceptions of and involvement in their treatment.

Participants were invited in person to take part in the study, and an interview time was scheduled after they provided consent. The informed consent form was presented and read together with the participant, and the interview began once it had been signed.

Patient interviews were conducted by nursing students after receiving training on the topic, data collection techniques, and ethical considerations. Interviews took place at the bedside, with a screen used to maintain privacy, and lasted an average of eight minutes. In some cases, patients requested assistance from family members in signing the informed consent form due to mobility limitations.

The study used audio recording with the interviewees' approval, followed by manual transcription by the team. The audio file and an editable transcript were then returned to the participants via WhatsApp for confirmation and/or modification of the information provided. Each interview was validated by comparing the returned file with the participants' feedback

or confirmation of the collected information. Participants were identified by the letter P (patient) followed by the questionnaire number.

Data processing and analysis

After the transcripts were validated by the participants, the data were organized into a corpus containing the interviews with patients and family members. The free and open-source software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRAMuTeQ), version 0.7 alpha 2, was used to perform lexical and vocabulary statistical analyses. This software is based on R, version 3.2.3. To ensure proper use of IRAMuTeQ, the corpus was prepared in Open Office (Apache), version 4.1.15, in .txt format. The starred line consisted of four asterisks followed by the participant identification (****p_01). The variables used were biological sex (*sex_1/*sex_2/*sex_0), where one indicated male, two female, and zero missing information, and hospitalization unit (*unit_1/*unit_2), where one indicated the Surgical Unit and two the Medical Unit.

The Descending Hierarchical Classification (DHC) method was used, in which the texts were classified according to their respective vocabularies, and the set of texts was divided by the frequency of the reduced forms[10]. From matrices that crossed text segments (TS) and words, chi-square tests were applied, adopting a p-value <0.05. The Reinert method was used to generate the DHC and obtain a stable and definitive classification[9]. The classification was straightforward, based on TS and other statistical criteria established by the software's predefined standardization. The software analyzed and segmented the corpus through statistical calculations until reaching the TS, which were described in the dendrogram of classes in Figure 1.

Content analysis was employed, which, in terms of interpretation, moves between two poles: the rigor of objectivity and the richness of subjectivity. It is a refined technique that requires discipline, dedication, patience, and time from the researcher. A degree of intuition, imagination, and creativity is also necessary, especially when defining the categories of analysis, while never neglecting rigor and ethics, which are essential[10].

Content analysis, according to Bardin[10], follows three stages. The first, pre-analysis, involves organizing the material to be analyzed. Based on validated interview transcripts, the

corpus was constructed manually and carefully to allow the researcher to integrate the information provided by participants. The second stage, categorization, involves exploring the corpus, defining the logical sequence, and performing pairwise merging. This stage allows for the identification of emerging themes from the data. In this stage, the IRAMUTEQ software assists by highlighting the most significant content in the corpus, using chi-square tests and generating the DHC. The corpus-coloring feature, produced by IRAMUTEQ, was also used to group the text segments identified through the software analysis. Finally, the last stage, inference, involves interpreting themes and statements critically and reflectively within each proposed category, after which the results are described, thus concluding the content analysis[11].

Ethical aspects

The study complied with ethical principles for research involving human subjects and was approved by the Research Ethics Committee (CAAE No. 73679623.4.0000.5324), and by the institution's Teaching and Research Management. Participants were informed of the research objectives, rationale, data collection procedures, potential risks and benefits, confidentiality, anonymity, and academic use of the data. They were also informed that participation was voluntary, without financial compensation, and that they could withdraw at any time without consequences.

RESULTS

Participant characterization

This study involved 31 patients: 16 admitted to the MU and 15 to the SU. All were over 18 years of age, with a mean age of 49.2 years (SD ± 15.21). Most participants reported being female, and the majority were residents of the study city.

According to the data processed in IRAMUTEQ, the corpus derived from patient interviews consisted of 31 texts, divided into 364 TS, with 79.40% utilization corresponding to 289 TS. The classes resulting from the DHC analysis in IRAMUTEQ generated a dendrogram, as shown in the figure below: class one represented 21.4%, class two 15.9%, class three 15.6%, class four 15.9%, class five 16.6%, and class six 14.5%.

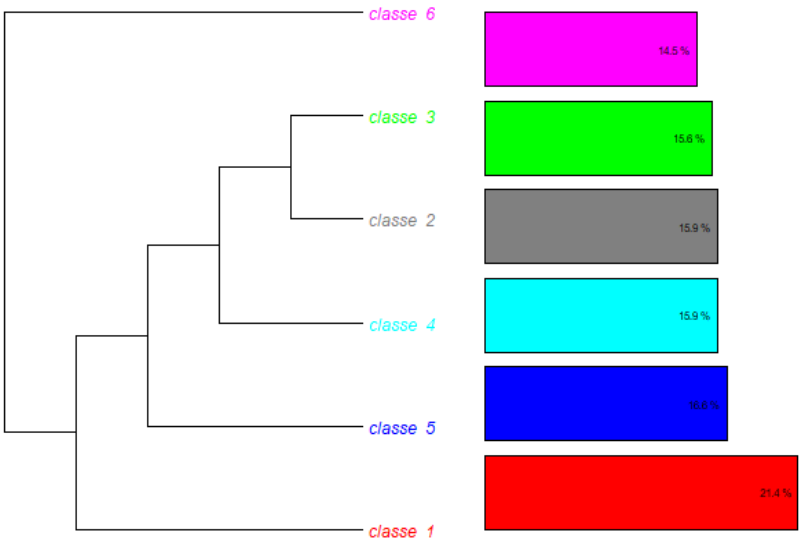

Figure 1. Descending Hierarchical Classification of patients, performed with IRAMUTEQ. Source: Authors

The categories were constructed based on the Institute of Medicine's (IOM) guiding principles for patient-centered care, and four categories emerged: respecting patient preferences; information, education, and integration of care; physical comfort and emotional support; and access to care.

Respecting patient preferences

Patients highlighted the respect and attention given to the explanation of all procedures, which made them feel fully informed about what they were receiving and why. This reinforced their autonomy and involvement in their care.

This practice not only ensures that patients feel respected during hospitalization but also establishes a foundation of trust and transparency between them and the care team. Nursing professionals responded promptly to calls, provided personalized, high-quality care at the bedside, and contributed to a more peaceful and positive hospitalization experience.

> “When they come to the room, they tell me to let them know if I feel anything. They explain all the medications they will administer, so I feel respected in the procedures that affect my integrity. This part is very meticulous” (P07)
> “Regarding the medications administered, they give them at the right time. When I ask, they explain what it is for and I feel respected; everyone is very respectful, and they make us feel at ease” (P10)

> “They explain the medications before administering them. I definitely feel respected. Many helped with the peripheral venous access that was in the vein, but I was still in a lot of pain, so they came and changed it” (P15)

> “They explain before applying the procedures. There is respect in the care provided here, and the service is excellent” (P25)

Respect for beliefs and the absence of medication or procedural errors were reported as factors that promote patient engagement in treatment and foster feelings of safety and trust in the team. These aspects contribute to a more positive hospital experience.

> "The interaction with health professionals is good. I feel included in the treatment, and I think my beliefs and questions are respected. So far, I haven't experienced any physiological changes." (P09)

> "I'm well-assisted by the professionals. The team is very nice and polite, and they act quickly to help. I've felt calm since I arrived because I already knew what I had and what they were going to do." (P14)

> “I feel respected during the procedures. I was treated very well, I didn’t feel any discomfort, and there were no medication or procedure errors” (P16)

> “Always telling me to stay calm and remind me that I’m not alone, especially since I came from another city.” (P22)

Information, education, and integration of care

The clear and attentive information provided by healthcare professionals empowered patients to understand and guide their caregivers regarding their needs. This fostered a sense of care and support, which was evident in their reports, particularly in how the unit staff welcomed them, provided detailed explanations about hospital routines, and conducted a thorough medical history.

> “I was welcomed. When I was admitted to the unit, they explained everything they would do. The health professionals come to my bed frequently, and they are very attentive.” (P03)

> "I was very well received, and the service was fast. I receive information every morning. They come to my bedside frequently, more than once a day." (P26)

Regarding communication with the team, patients consistently praised the nursing teams across all three shifts for their collaboration and engagement during the weekdays, although some noted reduced contact on the weekends. All concerns, questions, and information regarding patients' health status were promptly addressed, demonstrating effective communication. Building a strong, trusting relationship between patients and the healthcare team is essential to fostering a comprehensive care environment that is responsive to patients' needs.

> "Great, my health is good now. They come and explain everything to me. When the shift changes, they explain everything clearly." (P29)

> “As for bedside visits, I can't specify the shifts and times, but they come once or twice. Yes, I feel safe. The service is good, the timing is correct, and everything is in order” (P20)

> “I receive information once a day in the morning, but it's more difficult to get it regularly on weekends. On weekdays, nursing professionals come and talk to me about five or six times a day.” (P31)

> They welcomed me when I was admitted. They always give me information when I need it. The physician comes once a day, and the nursing staff visit me frequently" (P18)

Physical comfort and emotional support

Hospitalization is often perceived as a challenge by patients; however, their reports emphasized a warm and welcoming atmosphere, reinforcing the team's commitment to providing patient-centered care that prioritizes both physical and emotional needs throughout hospitalization.

> "I have a feeling of security." (P26)

> "I was well received. The healthcare team provided prompt care, and upon arrival, they gave me medication to relieve my pain." (P30)

Hospitalization, surgery, and separation from family can trigger feelings of anxiety, worry, and sadness. However, patients appreciated personalized treatment and emotional support, which provided a less distressing experience—a fundamental aspect of patient-centered care.

This support goes beyond physical treatment, encompassing patients' emotional and psychological needs and creating a caring environment that recognizes and validates their emotions.

> "I have an anxiety disorder, and it manifested here, but all the health professionals were willing to listen and understand, which made me feel calmer. Last night, when I had very severe pain and the medication was administered quickly, they understood that I needed a stronger dose." (P12)

> "I feel calmer, but when it's time to sleep I feel sad and worried because I want to leave. Still, I'm treated well, and they care for me more than necessary here" (P28)

> "I was more anxious and worried about having the surgery again, but everything has been great. The interaction with health professionals is very

> good—I would rate it a million points. The care for my family downstairs is also great; they are well received, I have no complaints" (P06)
>
> "The only thing that worries me is my dogs at home. My mother said they are sad because they don't see me. I love my pets" (P21)
>
> "I feel calmer now, because when I came here I was unconscious, but my brain was awake. I remember everything—I had negative thoughts and nightmares, I felt sadder and more worried. They are so sweet, they are very respectful." (P27)

Access to care

Participants perceived the inpatient unit not only as a safe and welcoming environment but also as a place where their needs were heard, prioritized, and respected. The presence of policies and security measures enhanced their sense of peace and safety during hospitalization, reflecting the institution's commitment to patient safety.

Meticulous organization and rigorous sanitation, quality lighting, and adequate nutrition—with meals provided by the hospital staff—are crucial to patient comfort and recovery. Combined, these elements not only create a safe and pleasant environment but also reflect the essence of patient-centered care, in which every aspect of the hospital environment is carefully planned to meet individual needs and promote a supportive hospital stay.

> "I feel safe in this environment because there is a night guard, caregivers are present, and the gate is locked. No one enters without permission, I don't know, but I feel safe because I see the guard pass by at night" (P04)
>
> "It's an airy environment. The bed can be moved up and down, as well as adjusted in different directions. The bathroom is very clean—they are always cleaning it" (P06)
>
> "The environment is great, very clean, I like the hygiene and everything, and during this period I have not experienced any dissatisfaction" (P08)

> "The environment is well-lit, and they give us good food. They are caring" (P13)

> "The environment is good and welcoming. There is noise from the medication pumps and everything else, but after all, it is a hospital" (P19)

DISCUSSION

Patient-centered care is breaking down barriers and gaining momentum, driving the integration of health promotion activities into clinical practice and empowering patients to become active participants in their care[11]. Person-centered care emerges from patients' individual needs and preferences, seeking to ensure satisfaction, participation, and safety. Therefore, in addition to promoting active participation in their own care to strengthen their role and autonomy, it is essential that healthcare professionals explain all procedures before they are carried out, informing, empowering, and involving patients in the care process[12] .

In this study, patients reported experiencing respect and receiving clear explanations about their treatment, which strengthened their autonomy and involvement in their own care. This practice values the patient, promotes trust and transparency, and, combined with the nursing team's rapid response to calls, ensures personalized and humanized care, making the hospitalization more peaceful and positive. Respect for beliefs and the absence of errors were also evidenced, fostering patient participation in care, in addition to generating safety, trust in the team, and a more positive hospital experience.

Patients' individual knowledge of medical terms and their information needs are often inaccurately identified, while their health literacy tends to be overestimated. This situation can compromise the effectiveness of communication between patients and healthcare professionals, resulting in barriers to understanding guidance[13]. When healthcare professionals empower and involve both patients and families in the care process, patient outcomes tend to be more positive[14].

Patients perceived the information provided as clear and attentive. When well informed, they feel empowered to participate in clinical decision making, guiding professionals according to their needs. This creates a sense of care and acceptance, evidenced by reports of the attentive manner in which the team welcomes them, explains routines, and

collects medical history. Communication with the team was praised, highlighting the nursing staff engagement on weekdays, despite less contact on weekends. Questions were promptly clarified, reflecting patient-centered care with a focus on clarity, acceptance, and mutual trust.

Corroborating this finding, a previous study[15] highlighted that the person-centered model not only promotes the inclusion of patients in their care process but also fosters a relationship of trust with professionals, contributing to a safer and more satisfactory hospital experience.

Communication is considered a complex process that encompasses different modes of expression beyond speech, requiring that the possibilities of understanding be expanded to ensure clarity among team members, patients, and family members. In this sense, the act of communicating requires a series of considerations, as it must be clear and objective to ensure that the quality of the message transmitted and received is satisfactory. However, the literature indicates that in clinical settings, nurses generally collect personalized information only at the time of hospital admission through nursing history taking. Heavy workloads, however, hinder the continuous reassessment of patients' preferences and needs, as well as the incorporation of these dimensions into care planning and delivery.

A previous study[18] found that 60.9% of participating patients reported receiving patient-centered care, while the remaining 39% did not receive care that was respectful and sensitive to their preferences, needs, and values. Regarding the perception of healthcare professionals, most reported that patients' preferences and needs were well understood and respected. However, discrepancies remain in the provision of care, as it sometimes does not align with what patients prefer in a hospital setting, and expectations may include inappropriate or unnecessary services for their health conditions[17].

In our findings, participants emphasized that despite the challenges of hospitalization and the anxiety of being separated from their family environment, they received a warm welcome and focused care that integrated physical and emotional support from the moment of admission. Personalized treatment and the validation of emotions alleviated suffering and strengthened confidence in the process.

Holistic care also encompasses attention to psychosocial needs, guiding patients in coping with emotional and social issues such as anxiety and social isolation[18]. The positive

effects of strong relationships between healthcare professionals and patients contribute to improved quality of care, with immediate benefits for health and the promotion of a safe hospital environment[19].

Contrary to our findings, a study[20] conducted with 600 patients in Bahir Dar, Ethiopia, showed that 170 (56.7%) of those treated in public hospitals and 144 (48%) treated in private hospitals did not know their healthcare professionals during their care. Furthermore, more than half of the 196 (65.3%) patients in public hospitals and 121 (40.3%) in private hospitals were not involved in decision making during their care.

The patients in our study perceived the inpatient unit as an environment where their needs were heard, prioritized, and respected. They also highlighted that the reception and security measures reinforced a sense of tranquility and protection during hospitalization, demonstrating a commitment to patient safety. The meticulous organization—rigorous sanitation, good lighting, and adequate meals—contributed to comfort and supported recovery. Together, these elements reflect patient-centered care, in which every detail of the environment is planned for a more comforting stay.

According to the literature[21], the hospital environment has a significant impact on hospitalization and the promotion of patient-centered care. Therefore, improving hospital conditions promotes care that considers the patient as a whole, not just the disease. Disinfection and cleaning of hospital areas are essential components for creating a comfortable environment and promoting safety, comfort, and well-being for patients, their families, and healthcare professionals[22].

A study of primary care physicians found that they recognized the importance of communication in facilitating patient-centered care. They also highlighted that allocating resources to identify patient values and priorities can foster alignment between professionals and patients around common care goals, promoting greater engagement. In addition, applying conflict resolution techniques can strengthen the relationship between healthcare professionals and patients, contributing to the perception of greater ease in delivering person-centered care. Incorporating these factors into healthcare systems can enhance the quality and effectiveness of care provided to vulnerable populations[23].

Thus, a strong relationship between healthcare professionals and patients has positive effects, contributing to improved quality of care, faster recovery, and the promotion of a safe hospital environment[19]. Considering patients' personal aspects requires improving the perceptions and attitudes of nursing staff, as well as strengthening institutional policies and initiatives within the hospital setting. In addition, the government should reallocate the nursing workforce and review the patient-to-nurse ratio to reduce workload and prevent professional burnout among nursing staff[13].

CONCLUSIONS

The patient experience of patient-centered care during hospitalization demonstrates satisfaction with care, especially when patients receive guidance and are included in their care process. A safe environment is associated with both structural and behavioral factors. When family members are included, the support network during care becomes more consolidated, enabling greater openness in healthcare and delivering safe, structured care.

Effective communication emerged as the central theme among study participants, representing an inseparable part of patient care in all healthcare settings and a key factor in determining the quality of care.

There is insufficient empirical research in Brazil on patient-centered care that explicitly recognizes it as a dimension of health service quality. Perceptions of patient-centered care in the Brazilian healthcare context differ from those observed in developed countries. Therefore, it is necessary to encourage and strengthen research on patient-centered care as a facilitator of quality healthcare.

This study’s limitation lies in its conduct at a single university hospital, which hinders the generalization of findings.

REFERENCES

1. Ventura F, Moreira, I; Raposo V, Queirós PJP, Mendes, A. A prática centrada na pessoa: da idiossincrasia do cuidar à inovação em saúde. Caderno Saúde Pública. 2022;8(10):e00278121. DOI: https://doi.org/10.1590/0102-311XPT278121

2. INSTITUTE OF MEDICINE. Crossing the Quality Chasm: A New Health System for the 21st Century; Washington, 2018.

3. Ribeiro, RV; Signor E, Forgiarini G. Theoretical approach to the concept of Person-Centered Care: An integrative literature review. Research, Society and Development. 2023;12(10):e59121043453. DOI: https://doi.org/10.33448/rsd-v12i10.43453

4. Okeny P, Pittalis C, Monaghan CF, Brugha, R, Gajewski J. Dimensions of patient-centred care from the perspective of patients and healthcare workers in hospital settings in sub-Saharan Africa: A qualitative evidence synthesis. PloS one, 2024;19(4): e0299627. DOI: https://doi.org/10.1371/journal.pone.0299627

5. Kwame A, Petrucka PM. A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. BMC Nurs. 2021;20(1):158. DOI: http://dx.doi.org/10.1186/s12912-021-00684-2.

6. Lilleheie I, Debesay J, Bye A, Bergland A. Experiences of elderly patients regarding participation in their hospital discharge: a qualitative metasummary. BMJ Open. 2019;3;9(11):e025789. DOI: https://doi.org/10.1136/bmjopen-2018-025789.

7. Tong A, Sainsbury P, Craig J. Consolida-te criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349–57. DOI: https://doi.org/10.1093/intqhc/mzm042

8. Ministério da Educação. História Empresa Brasileira de Serviços Hospitalares EBSERH. 2020. Atual em 2023. Disponível em: Relatos e Histórias — Empresa Brasileira de Serviços Hospitalares (www.gov.br).Acesso em: 26 set. 2024.

9. Silva, R; Ribeiro EAW. O software IRAMUTEQ como ferramenta metodológica para análise qualitativa nas pesquisas em educação profissional e tecnológica. BRAJETS. 2021;14(2):275-84. DOI: https://10.14571/brajets.v14.n2.275-284

10. Bardin L. Análise de Conteúdo. São Paulo: Edições 70; 2016.

11. Lima LAR, Santos BB, Barros CL, Santos AL. Conceito e implementação do cuidado centrado na pessoa na perspectiva do médico da estratégia saúde da família. Braz J Develop. 2020;6(9):7378699. DOI: http://dx.doi.org/10.34117/bjdv6n9-728

12. Ferreira JDO, Campos TNC, Dias DEM, Silva IL, Dantas TH, Dantas DS. Estratégias de humanização da assistência no ambiente hospitalar: revisão integrativa. Revista Ciência Plural. 2021;7(1):147-163, 2021. DOI: https://doi.org/10.21680/2446-7286.2021v7n1ID23011

13. Yang Y.Efects of health literacy competencies on patient-centered care among nurses BMC Health Services Research. 2022.22:1172. DOI: 10.1186/s12913-022-08550-w

14. Tinetti ME, Naik AD, Dindo L, Costello DM, Esterson J, Geda M, et al. Association of Patient Priorities-Aligned Decision-Making With Patient Outcomes and Ambulatory Health Care Burden Among Older Adults With Multiple Chronic Conditions: A Nonrandomized Clinical Trial. JAMA Intern Med. 2019;179(12):1688-1697. DOI: https://doi.org/10.1001/jamainternmed.2019.4235.

15. Antoine A, Fitchett G, Marin D, Sharma V, Garman A, Haythorn T, et al. What organizational and business models underlie the provision of spiritual care in healthcare organizations? An initial description and analysis. J Health Care Chaplain. 2022:28(2):272-284. DOI: http://dx.doi.org/10.1080/08854726.2020.1861535.

16. DeRosa AP, Baltich Nelson B, Delgado D, Mages KC, Martin L, Stribling JC. Involvement of information professionals in patient- and family-centered care initiatives: a scoping review. J Med Libr Assoc. 2019,107(3):314-322. DOI: https://doi.org/10.5195/jmla.2019.652.

17. Almeida HOC, Góis RMO. Avaliação da satisfação do paciente: indicadores assistenciais de qualidade. Rev. Adm. Saúde, 2020, 20(81),e244. DOI: http://dx.doi.org/10.23973/ras.81.244

18. G/egziabher R, Biks GA, Worku N, Endalew B, Dellie E. Patient-Centered Care and Associated Factors among Adult Admitted Patients in South Wollo Public Hospitals, Northeast Ethiopia. Patient Preference and Adherence. 2022;16, 333–342. DOI: 10.2147/PPA.S346000

19. Adetunji A, Bishai D, Pham CV, Taylor J, Thi NT, Khan Z, et al. Patient-centered care and geriatric knowledge translation among healthcare providers in Vietnam: translation and validation of the patient-centered care measure. MC Health Serv Res. 2023.19;23(1):379. DOI: 10.1186/s12913-023-09311-z

20. Metz A, Albers B, Burke K, Bartley L, Louison L, Ward C, et al. Implementation Practice in Human Service Systems: Understanding the Principles and Competencies of Professionals Who Support Implementation. Human Service Organizations: Management, Leadership & Governance. 2021;45(3), 238–259. DOI :https://doi.org/10.1080/23303131.2021.1895401

21. Ewunetu M, Temesgen W, Zewdu D, Andargie A, Kebede M, Lidetu T. Patients' Perception of Patient-Centered Care and Associated Factors Among Patients Admitted in Private and Public Hospitals: A Comparative Cross-Sectional Study. Patient Prefer Adherence. 2023. 17;17:1035-1047. doi: 10.2147/PPA.S402262.

22. Castro EM, Van Regenmortel T, Vanhaecht K, Sermeus W, Van Hecke A. Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review. Patient Educ Couns. 2016;99(12):1923-1939. DOI: http://dx.doi.org/10.1016/j.pec.2016.07.026

23. Bates DW, Singh H. Two Decades Since To Err Is Human: An Assessment Of Progress And Emerging Priorities In Patient Safety. Health Aff (Millwood). 2018 Nov;37(11):1736-1743. DOI: http://dx.doi.org/10.1377/hlthaff.2018.0738. PMID: 30395508.

24. Souza MF, Viana VC, Silva MC, Guimarães CCV, Cruz VOO, Beatriz GCA, et al. Brazilian Journal of Development. 2019;5(12):29325-29327. DOI: https://doi.org/10.34117/bjdv5n12-090

25. Schuttner L, Hockett Sherlock S, Simons CE, Johnson NL, Wirtz E, Ralston JD, et al. My Goals Are Not Their Goals: Barriers and Facilitators to Delivery of Patient-Centered Care for Patients with Multimorbidity. J Gen Intern Med. 2022;37(16):4189-4196. DOI: 10.1007/s11606-022-07533-1.

Submitted: December 29, 2024

Accepted: May 20, 2025

Published: September 15, 2025

Authors' contributions	
Natalia Antiqueira Garcia:	Conceptualization. Data curation. Formal analysis. O Funding acquisition. Investigation. Methodology. Resources.
Laurelize Pereira Rocha:	Conceptualization. Funding acquisition. Methodology. Project administration. Resources. Supervision.
Raissa Garcia Brum:	Data curation. Formal analysis. Investigation.
Laís Farias Juliano:	Data curation. Formal analysis
Caroline Passos Arruda:	Data curation. Formal analysis
Julia Severo dos Santos:	Data curation. Formal analysis
All authors approved the final version of the text.	
Conflict of interest:	There is no conflict of interest.

PATIENT-CENTERED CARE: A STUDY IN A CLINICAL AND SURGICAL HOSPITALIZATION UNIT

Financing:	No financing.

Corresponding author:	Raissa Garcia Brum Universidade Federal do Rio Grande – FURG Km 8 Avenida Itália Carreiros, Rio Grande/RS, Brazil. CEP 96203-900 raissagbrum@gmail.com

Editor-in-chief:	Adriane Cristina Bernat Kolankiewicz. PhD